OPTIONAL ADVANCE HEALTH CARE DIRECTIVE

Date

Your Name: Last First Middle Initial

Street Address City State Zip

PART 1: INDIVIDUAL INSTRUCTIONS FOR HEALTH CARE

(INITIAL ONLY ONE (1) CHOICE IN EACH SECTION, and CROSS OUT ALL THAT DO NOT APPLY.)

The following statements only apply:

- if I am close to death and life support would only postpone the moment of my death **OR**
- if I am in an unconscious state such as irreversible coma or a persistent vegetative state and it is unlikely that I will ever become conscious **OR**
- if I have brain damage or a brain disease that makes me permanently unable to make and communicate health-care decisions about myself.

A. CHOICE TO PROLONG OR NOT TO PROLONG LIFE

_____ YES, I do want to have my life prolonged as long as possible within the limits of generally accepted health-care standards that apply to my condition.
OR
_____ NO, I do not want my life prolonged.

B. ARTIFICIAL NUTRITION AND HYDRATION (FOOD AND FLUIDS) BY TUBE INTO STOMACH OR VEIN

_____ YES, I do want artificial nutrition and hydration.
OR
_____ NO, I do not want artificial nutrition and hydration.

C. RELIEF FROM PAIN

_____ YES, I do want treatment to relieve my pain or discomfort.
OR
_____ NO, I do not want treatment to relieve my pain or discomfort.

D. ETHICAL, RELIGIOUS, OR SPIRITUAL INSTRUCTIONS (OPTIONAL)

Is there a church, temple, spiritual group, or a special person from whom you wish to receive spiritual care?

Your Name: **Phone**

Street Address **City** **State** **Zip**

E. WHERE I WANT TO DIE (CHOOSE ONE):

_____ Home _____ Hospital _____ Nursing Home

Do you want hospice care?: _____ YES _____ NO
(Available in all these settings, hospice is medical, psycho-social, and spiritual support for patient and family during and after the end of life.)

F. OTHER WISHES:

If you do not agree with any of the choices above or wish to add other instructions, including body and organ donation, you may add pages. If you are or could become pregnant, consult your doctor, and consider adding special instructions suspending or adding provisions.

PART 2: HEALTH CARE POWER OF ATTORNEY AGENT'S AUTHORITY AND OBLIGATION

My agent shall make health-care decisions for me in accordance with my best interests and wishes so far as they are known. In determining my best interest, my agent shall consider my personal values. If a guardian of my person needs to be appointed for me by a court, I nominate my agent. I designate the following individual as my agent. He/she may make all health-care decisions for me if I am unable or unwilling to make them for myself unless I direct otherwise.

Name of Agent (Spouse, adult child, friend, or trusted person) **Relationship**

Street Address **City** **State** **Zip**

Home Phone **Work Phone** **E-Mail**

If my agent is not available, I designate the following person as my alternative agent:

Name of Alternative Agent (Spouse, adult child, friend, or other trusted person)

Name of Agent (Spouse, adult child, friend, or trusted person) **Relationship**

Street Address **City** **State** **Zip**

Home Phone **Work Phone** **E-Mail**

_____ My agent may make all health-care decisions for me.

OR

_____ My agent may make all health-care decisions for me except: _____

_____

_____ My agent's authority to make health-care decisions for me takes effect immediately.

OR

_____ My agent's authority becomes effective when my primary physician determines that I am unable to make health-care decisions.

Important: Witnesses cannot be your health-care agent, a health-care provider, or an employee of a health-care facility. One witness cannot be a relative or have inheritance rights.

Print Your Name	Your Signature	Date

OPTION 1: WITNESSES

Witness #1 Print Name	Witness Signature	Date

Street Address	City	State	Zip Code

Witness #2 Print Name	Witness Signature	Date

Street Address	City	State	Zip Code

OPTION 2: NOTARY PUBLIC

State of Hawai'i, _____ (County)
On this _____ day of _____, in the year _____, before me, _____ _____, (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument and acknowledged that he or she executed it.

_____

My Commission Expires: _____

A copy has the same effect as the original.

Developed by the Executive Office on Aging, State of Hawai'i – Revised December 2000